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RECOMMENDATION FOLLOWING AN APPLICATION FOR REVIEW OF THE INSURER'S WORK CAPACITY DECISION PURSUANT TO SECTION 44(1)(c) OF THE *WORKERS COMPENSATION ACT* 1987*.*

1. The applicant, an injured worker, has applied for procedural review of a work capacity decision made by the Insurer on 12 July 2013. The decision is that weekly payments are to be reduced.

2. There is no dispute that the applicant was injured in the course of his full-time employment with the insured on 25 October 2007. The applicant did not return to his employment. The applicant has been able to maintain suitable employment with another employer since the injury. The Insurer made weekly payments as required under the provisions of the *Workers Compensation Act* 1987 (1987 Act).

3. The applicant was in receipt of compensation by way of weekly payments immediately before 1 October 2012. Clause 8 of Part 19H of Schedule 6 to the 1987 Act required the Insurer to conduct a work capacity assessment for the purpose of facilitating the transition of the amended weekly benefits provisions to the applicant's claim.

4. Section 44A of the 1987 Act provides that a work capacity assessment is an assessment of the injured worker's current work capacity and must be conducted in accordance with the *WorkCover Work Capacity Guidelines* (Guidelines).

5. The relevant version of the *Guidelines* is the one published on 27 September 2012 which applied to all claims from 1 January 2013. That publication stated that the *Guidelines* provide instructions and guidance to Insurers regarding the appropriate and consistent application of work capacity assessments and decisions.

6. Once the Insurer has conducted an assessment then the Insurer is required to make a work capacity decision. Where that decision involves a reduction in the weekly benefits payable to the injured worker[1] then

[1] Or cessation of weekly benefits.

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the Insurer is required to give proper notice to the worker (see section 54(2)(a) of the 1987 Act).

Submissions by the applicant

7. The applicant raised certain matters in the Application for Procedural Review. Section 44(1)(c) of the 1987 Act states that this review is *"only of the insurer's procedures in making the work capacity decision and not of any judgment or discretion exercised by the insurer".* The issues raised by the applicant go to the merits of his claim which are matters for the judgement and discretion of the insurer. They are therefore not relevant to this review.[2]

8. The Insurer did not make submissions.

The work capacity decision

9. The decision states that a work capacity assessment has been made. The decision does not state that this is a requirement pursuant to Clause 8 of Part 19H of Schedule 6 to the 1987 Act. As such the legislation has not been properly referenced as *Guideline* 5.4.2 requires. The insurer is required to make a decision "*as soon as practicable"* after the assessment is made: Clause 23, Schedule 8, *Workers Compensation Regulation* 2010. The decision does not state when the assessment was made. Therefore the applicant cannot know (and I cannot know) whether or not the decision was made *"as soon as practicable*" after the assessment.

10. There does not appear to be any legislative requirement to notify the applicant of the outcome of the assessment. However, *Guideline* 5.4.2 states that the decision must:

    - *state the decision and give brief reasons for making the decision;*

    - *outline the evidence considered in making the decision, noting the author, the date and any key information. All evidence considered should be referred to, regardless of whether or not it supports the decision;*

[2] See section 44(1)(c) of the 1987 Act.

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- *clearly explain the reasoning for the decision.*

My finding is that the *Guidelines* result in the insurer being compelled to reveal the outcome of the assessment.

11. *Guideline* 5.4.2 requires the Insurer *"to state the impact of the decision on the worker in terms of their entitlement to weekly payments, entitlement to medical and related treatment expenses and return to work obligations".* The decision states that "*any entitlement you may have to payment of pre-approved reasonable and necessary medical and other expenses, until 24 October 2014,* ***will not be affected****".*[3] This statement conveys no information to the applicant concerning the effect of the decision on such entitlements beyond 24 October 2014.[4] As weekly payments are being *reduced* and not *ceased*, the applicant is entitled to continuing medical expenses pursuant to section 60 of the 1987 Act.[5] It follows that the 1987 Act has been misrepresented and wrongly "explained" in this instance.

12. The decision also states that weekly payments at the "*current rate will continue to be paid until 24/10/2013 provided that certificates of capacity cover you until that date".* This statement is perfectly true, but as payments will be reduced the decision does not state that certificates of capacity will still be required after that date. An applicant may well be misled to wrongly assume that as the Insurer has made a decision in relation to his rate of pay that such certificates are not required.

13. The decision states that the decision is made pursuant to section 43 of the 1987 Act. *Guideline* 5.4.2 requires the Insurer to *"reference the relevant legislation".* The proper reference in this case is to section 43(1) of the 1987 Act.

14. The decision states that the Notice is given pursuant to section 54 of the 1987 Act. *Guideline* 5.4.2 requires the Insurer to *"reference the relevant*

[3] Emphasis added.
[4] Which may be a good thing, since there is no effect. See note 5 *infra*.
[5] Since section 59A(2) is not relevant, the question arises: What was being conveyed to the applicant by telling him that nothing would happen to his medical expenses entitlements until "24 October 2014"? The quoted statement is a stock sentence which appears in nearly every decision by this Insurer and I have yet to see an instance where it was either accurate or relevant.

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legislation". The proper reference in this case is to section 54(2)(a) of the 1987 Act. It should have been explained that section 54(2)(a) of the 1987 Act sets out that there is a 3 month notice period and that is the reason that the reduction in payments will occur on 24 October 2013, being the notice period plus extra time to allow for the delivery of the decision by post.

15. The applicant has received more than 130 weeks of weekly payments but the decision only states that the applicant has received 250 weeks of payments. The decision states that as a result of section 38 of the 1987 Act, weekly payments will reduce. The decision does attempt to explain why this will occur, with limited success. It states that pursuant to section 38 weekly payments are calculated at the rate of *"(AWE × 80%) − (E - D)."* The proper reference is to section 38(7). The proper calculation is actually *"(AWE × 80%) − (E + D)."* Further down the term "*AWE*" is explained as average weekly earnings. The decision states that the AWE is $938.30. This is described as the *"transitional amount",* and refers to section 43(1)(a) of the 1987 Act. The correct reference is to clauses 1, 2, and 9(3) of Part 19H of Schedule 6 to the 1987 Act. The decision does not refer to the definition of "*existing recipient of weekly payments"* in clause 1, or that this means a person in receipt of weekly payments immediately before 1 October 2012. The "*transitional amount"* is said to apply to workers who **made their claim** prior to 1 October 2012 which is incorrect.[6] The letters "*E*" and "*D*" are not explained. That would also have entailed referring to section 35 of the 1987 Act wherein the letters are defined.

16. The relevance of 250 weeks is not explained. The decision does not refer to section 32A of the 1987 Act and the definition of "*second entitlement period"* and that the definition refers to 130 weeks as being relevant. The legislation has not been properly referenced. This part of the decision is crowned with the sentence: *"You have a current capacity to work and have returned to work for not less than: please refer to Section 43(1)(a)of the Workers Compensation Act 1987."* For not less than what is kept secret. This sentence seems to be referring to section 38(3)(b) of the 1987 Act. A "*current capacity to work"* is not explained.

[6] It is "incorrect" in the sense that the true test is whether or not a person was in receipt of payments at the relevant time, not whether or not they had made a claim. It is incontrovertibly true that the claim must have been made before the relevant date, but while that is a necessary requirement, it is not a sufficient one.

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That would have involved a reference to section 32A of the 1987 Act and the definition of "*current work capacity."*

17. The decision states that the applicant is assessed as able to earn a certain amount in suitable employment and refers to section 43(1)(c) and (d) of the 1987 Act. Such a reference would do little to assist the applicant. Further down the decision sets out the definition of *"suitable employment"* in 2 paragraphs. At the end of the second paragraph the reference is given to section 32A of the 1987 Act. An applicant may not know that the first paragraph is also part of section 32A, or that the definition is not to be found in section 43(1)(c) and (d) of the 1987 Act.

18. The decision states that the "*following occupations have been identified as suitable employment for you"* and then lists the applicant's current employer rather than any job that the applicant is doing for that employer. Nothing else is listed. The definition of "*suitable employment"* does not include any reference to an employer. Both a Vocational Assessment Report and a Vocational Programme Report are listed. The Vocational Assessment Report dated 3 November 2011 refers to 3 options with the current employer, but for 2 of those the applicant needs training. The applicant had completed training for at least one of those jobs by 2012. The decision should refer to types of employment, and then determine which type or types of employment are *"suitable employment".*

19. The applicant is then advised that in "*making this decision we have reviewed and considered the following information*." The decision then lists 16 documents. A statement is then made that *"The information which supports our decision indicates that you have a capacity to work full time." Guideline* 5.4.2 requires the Insurer to "*outline the evidence considered in making the decision, noting the author, the date and any key information. All evidence considered should be referred to, regardless of whether or not it supports the decision."* No evidence has been referred to in the decision. No key information has been referred to in the decision. Whether or not any evidence does not support the decision is studiously avoided.

20. *Guideline* 5.4.2, which has not been referred to, also states that the work capacity decision notice must advise the applicant that any documents or information that have not already been provided to the applicant can

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be provided on request to the Insurer. The Insurer has failed to so advise the applicant. The Insurer states that further copies of documents already provided can be made available. The Insurer does not state that there are no other documents. The insurer's statement suggests to an applicant that there are no other relevant documents. An applicant may well disagree if he has the opportunity to peruse such other documents. Further, the Internal Review Decision of 30 August 2013 refers to a document called a *"Vocational Program Details"* which is not referred to in the decision. The Vocational Assessment Report dated 3 November 2011referred to in paragraph 18 is not listed in the decision which refers to a report of the same name dated 23 November 2011. The Internal Review Decision refers to the 3 November 2011 report. By this time the applicant might very well be concerned that there may be documents held by the Insurer and, perhaps, ignored by the Insurer when making the decision.

21. The applicant is advised that he may request an internal review. The Insurer has not referred to section 44(1)(a) of the 1987 Act. This is a breach of *Guideline* 5.4.2 and the need to *"reference the relevant legislation".* The Insurer states that the request can be made by facsimile or email. The Insurer does not say that such a request can alternatively be made by post. An applicant may not have electronic means of transmitting an application for review. This is aggravated by the Insurer only being able to serve the decision in person or by mail pursuant to section 54(4) of the 1987 Act.

22. The applicant is advised that the application for internal review must be sent within 30 days of receiving the decision. That is not what the 1987 Act says. Section 44(1)(a) of the 1987 Act allows for the applicant to seek an internal review, but with no time limit. The *Guidelines for work capacity decision Internal Reviews by insurers and Merit Reviews by the WorkCover Authority* 6.5 which came into effect on 1 January 2013 stated that the application for internal review must be lodged within 30 day of receipt of the decision. This was in conflict with the Act. The Insurer may have been comforted by that *Guideline*, but the next iteration of *Guideline* 6.5 which came into effect on 11 October 2013 corrected itself and the guideline now states that the applicant should lodge the application "*as soon as practicable after receiving*" the decision.

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23. The advice as to the internal review states that the application form should be completed and returned *"to us with the extra information, reports and/or documents you rely upon"* (emphasis added). This statement conveys the impression that an applicant must provide further evidence or information in order to make an application for internal review. That is misleading. The applicant may request an internal review pursuant to section 44 of the 1987 Act whether or not further evidence or information is available or submitted. Section 44(2) only requires the applicant to provide *grounds* for seeking review.

24. The applicant is advised that if he is dissatisfied with the internal review he may seek a merit review from WorkCover. Again, the Insurer has not referred to section 44 of the 1987 Act. The applicant is also advised that WorkCover will *"provide a response to you within 30 days of receipt of your request."* This time frame is set out in the *Guidelines for work capacity decision Internal Reviews by Insurers and Merit Reviews by the Authority* dated 11 October 2013. *Guideline* 10.14 states "*The Authority will write to the worker and insurer as soon as practicable and preferably within 30 days of receiving the application advising of the outcome of the merit review."* The Authority received the application for review on 30 September 2013 and issued the review on 30 January 2014, some 122 days later. It seems that *Guideline* 10.14 is one for the breach of which there exists no current remedy. This delay explains (at least in part) why a procedural review is being conducted in March 2014 of a work capacity decision dated 12 July 2014.

25. Attached to, and forming part of the decision, are excerpts from the 1987 Act totalling nearly 6 pages. These pages have the heading "*Key Sections of the Workers Compensation Act NSW 1987 referred to within this Notice."* Nothing could be further from the truth. These pages set out sections 32A, 36, 37, 38, 43, 44, 44A and 54 of the 1987 Act in full. Sections 36, 37, 44, and 44A are not referred to in the decision. Sections 36 and 37 do not apply to the applicant's circumstances. Only parts of some of the other sections are relevant particularly in regard to section 38. Section 35 is not referred to in the decision and not re-produced in the 6 pages. Not having explained and referred to the relevant sections in the body of the decision and then providing 6 pages

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of excerpts is far from explaining the decision in plain language as required by *Guideline* 5.4.1.

26. The decision states that it was made by [senior case manager] and reviewed and affirmed by [team leader]. Under the signature at the end of the decision it says *"[senior case manager] for [senior specialist case manager]".* It is unclear who made the decision. Proper identification of the person making the decision is important as an internal review must be done by a person who was not involved with the decision pursuant to *Guidelines for work capacity decision Internal Reviews by Insurers and Merit Reviews by the Authority* 7.2.

27. For internal reviews the decision states that the Insurer may reject "*frivolous and vexatious applications*". This statement is supported by the *Guidelines for work capacity decision Internal Reviews by Insurers and Merit Reviews by the Authority* 6.7. Again, the Authority, in drafting the *Guidelines*, has miscontrued the legislation by misapplying it to internal reviews,[7] whereas section 44(3)(c) of the 1987 Act uses the phrase "*frivolous* ***or*** *vexatious"* and that section only relates to merit reviews and procedural reviews. An Insurer cannot refuse to undertake an internal review on the basis that it is "*frivolous or vexatious."*

FINDING

28. I find that the Insurer has failed to follow the procedures as set out in the WorkCover *Guidelines* which is required by Section 44A of the 1987 Act. The Insurer has also failed to follow and correctly apply the 1987 Act and the *Workers Compensation Regulation* 2010.

RECOMMENDATION

29. I recommend that the Insurer conduct a new work capacity assessment and, if appropriate, make a new work capacity decision in accordance with the WorkCover *Guidelines*.

30. I recommend that the Insurer pay the applicant the weekly benefit to which he was entitled prior to 12 July 2013 until such time as he is

[7] Although it did quote the *wording* of the section correctly, it wrongly applied the section to internal reviews. Despite this error concerning such petty terms as "frivolous" and/or "vexatious," it remains such a breach of the correct procedure as will allow of no minoration on that account.

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properly transitioned. Those payments should continue from 24 October 2013 being the date on which they ceased.

31. Since the applicant is currently in receipt of weekly payments (albeit reduced), it might be thought that clause 21 of schedule 8 of the *Regulation* can apply and increased payments may not therefore resume immediately. In my view this is incorect, since the applicant is covered by section 33 of the 1987 Act which requires compensation to be paid "during the incapacity." The entitlement to compensation is a right subsisting in law and ought to be enforceable without any delay. There is nothing in the 1987 Act or the 1998 Act justifying clause 21 of schedule 8 to the *Regulation* which is clearly in conflict with section 33. On that basis I recommend that payments at the increased former rate recommence forthwith, back-dated to 24 October 2013.

32. The applicant is not required to produce work capacity certificates for the period from 24 October 2013 to date by virtue of the operation of section 44B(2) of the 1987 Act.

33. These recommendations are binding on the insurer: see section 44(3)(h) of the 1987 Act.

Wayne Cooper
Delegate of the WorkCover Independent Review Officer
10 March 2014